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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05966

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05960

1. DECEASED-NAME (Type or print) First Middle Last Mary Elizabeth Forrest Anderson			2a. DATE OF DEATH Month Day Year April 1, 1969		2b. HOUR M
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH Nov. 25, 1891		6. AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH St. Mary's Md.		
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY St. Mary's	13c. CITY OR TOWN Lexington Park	13e. STREET AND NUMBER Rt. 1 Box 13A19	
14. FATHER'S NAME First Middle Last Daniel Forrest		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Kane			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 378-18-0184 2220-16-4507B		17. INFORMANT Address Edward I. Anderson same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse & Apoplexy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cachexia & Anorexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Carcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u> <u>wk</u> <u>mos.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968, to 4/1, 1969, that (I) (we) saw the deceased alive on 4/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James P. Jarboe M. D.</u>		22c. DATE SIGNED 4/1/69		22d. PHYSICIAN'S NAME (Type) James P. Jarboe M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 5, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Peter Clavers	
23d. LOCATION (City or Town) Ridge, St. Mary's, Maryland		23e. REC'D BY REGISTRAR DATE APR 7 1969		23f. REGISTRAR'S SIGNATURE Charles Judge	

27220

Fig. 1. 25, 40, 60, 80, 100, 120, 140, 160, 180, 200, 220, 240, 260, 280, 300, 320, 340, 360, 380, 400, 420, 440, 460, 480, 500, 520, 540, 560, 580, 600, 620, 640, 660, 680, 700, 720, 740, 760, 780, 800, 820, 840, 860, 880, 900, 920, 940, 960, 980, 1000, 1020, 1040, 1060, 1080, 1100, 1120, 1140, 1160, 1180, 1200, 1220, 1240, 1260, 1280, 1300, 1320, 1340, 1360, 1380, 1400, 1420, 1440, 1460, 1480, 1500, 1520, 1540, 1560, 1580, 1600, 1620, 1640, 1660, 1680, 1700, 1720, 1740, 1760, 1780, 1800, 1820, 1840, 1860, 1880, 1900, 1920, 1940, 1960, 1980, 2000, 2020, 2040, 2060, 2080, 2100, 2120, 2140, 2160, 2180, 2200, 2220, 2240, 2260, 2280, 2300, 2320, 2340, 2360, 2380, 2400, 2420, 2440, 2460, 2480, 2500, 2520, 2540, 2560, 2580, 2600, 2620, 2640, 2660, 2680, 2700, 2720, 2740, 2760, 2780, 2800, 2820, 2840, 2860, 2880, 2900, 2920, 2940, 2960, 2980, 3000, 3020, 3040, 3060, 3080, 3100, 3120, 3140, 3160, 3180, 3200, 3220, 3240, 3260, 3280, 3300, 3320, 3340, 3360, 3380, 3400, 3420, 3440, 3460, 3480, 3500, 3520, 3540, 3560, 3580, 3600, 3620, 3640, 3660, 3680, 3700, 3720, 3740, 3760, 3780, 3800, 3820, 3840, 3860, 3880, 3900, 3920, 3940, 3960, 3980, 4000, 4020, 4040, 4060, 4080, 4100, 4120, 4140, 4160, 4180, 4200, 4220, 4240, 4260, 4280, 4300, 4320, 4340, 4360, 4380, 4400, 4420, 4440, 4460, 4480, 4500, 4520, 4540, 4560, 4580, 4600, 4620, 4640, 4660, 4680, 4700, 4720, 4740, 4760, 4780, 4800, 4820, 4840, 4860, 4880, 4900, 4920, 4940, 4960, 4980, 5000, 5020, 5040, 5060, 5080, 5100, 5120, 5140, 5160, 5180, 5200, 5220, 5240, 5260, 5280, 5300, 5320, 5340, 5360, 5380, 5400, 5420, 5440, 5460, 5480, 5500, 5520, 5540, 5560, 5580, 5600, 5620, 5640, 5660, 5680, 5700, 5720, 5740, 5760, 5780, 5800, 5820, 5840, 5860, 5880, 5900, 5920, 5940, 5960, 5980, 6000, 6020, 6040, 6060, 6080, 6100, 6120, 6140, 6160, 6180, 6200, 6220, 6240, 6260, 6280, 6300, 6320, 6340, 6360, 6380, 6400, 6420, 6440, 6460, 6480, 6500, 6520, 6540, 6560, 6580, 6600, 6620, 6640, 6660, 6680, 6700, 6720, 6740, 6760, 6780, 6800, 6820, 6840, 6860, 6880, 6900, 6920, 6940, 6960, 6980, 7000, 7020, 7040, 7060, 7080, 7100, 7120, 7140, 7160, 7180, 7200, 7220, 7240, 7260, 7280, 7300, 7320, 7340, 7360, 7380, 7400, 7420, 7440, 7460, 7480, 7500, 7520, 7540, 7560, 7580, 7600, 7620, 7640, 7660, 7680, 7700, 7720, 7740, 7760, 7780, 7800, 7820, 7840, 7860, 7880, 7900, 7920, 7940, 7960, 7980, 8000, 8020, 8040, 8060, 8080, 8100, 8120, 8140, 8160, 8180, 8200, 8220, 8240, 8260, 8280, 8300, 8320, 8340, 8360, 8380, 8400, 8420, 8440, 8460, 8480, 8500, 8520, 8540, 8560, 8580, 8600, 8620, 8640, 8660, 8680, 8700, 8720, 8740, 8760, 8780, 8800, 8820, 8840, 8860, 8880, 8900, 8920, 8940, 8960, 8980, 9000, 9020, 9040, 9060, 9080, 9100, 9120, 9140, 9160, 9180, 9200, 9220, 9240, 9260, 9280, 9300, 9320, 9340, 9360, 9380, 9400, 9420, 9440, 9460, 9480, 9500, 9520, 9540, 9560, 9580, 9600, 9620, 9640, 9660, 9680, 9700, 9720, 9740, 9760, 9780, 9800, 9820, 9840, 9860, 9880, 9900, 9920, 9940, 9960, 9980, 10000, 10020, 10040, 10060, 10080, 10100, 10120, 10140, 10160, 10180, 10200, 10220, 10240, 10260, 10280, 10300, 10320, 10340, 10360, 10380, 10400, 10420, 10440, 10460, 10480, 10500, 10520, 10540, 10560, 10580, 10600, 10620, 10640, 10660, 10680, 10700, 10720, 10740, 10760, 10780, 10800, 10820, 10840, 10860, 10880, 10900, 10920, 10940, 10960, 10980, 11000, 11020, 11040, 11060, 11080, 11100, 11120, 11140, 11160, 11180, 11200, 11220, 11240, 11260, 11280, 11300, 11320, 11340, 11360, 11380, 11400, 11420, 11440, 11460, 11480, 11500, 11520, 11540, 11560, 11580, 11600, 11620, 11640, 11660, 11680, 11700, 11720, 11740, 11760, 11780, 11800, 11820, 11840, 11860, 11880, 11900, 11920, 11940, 11960, 11980, 12000, 12020, 12040, 12060, 12080, 12100, 12120, 12140, 12160, 12180, 12200, 12220, 12240, 12260, 12280, 12300, 12320, 12340, 12360, 12380, 12400, 12420, 12440, 12460, 12480, 12500, 12520, 12540, 12560, 12580, 12600, 12620, 12640, 12660, 12680, 12700, 12720, 12740, 12760, 12780, 12800, 12820, 12840, 12860, 12880, 12900, 12920, 12940, 12960, 12980, 13000, 13020, 13040, 13060, 13080, 13100, 13120, 13140, 13160, 13180, 13200, 13220, 13240, 13260,

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Q. Is it correct now, that I have said, that

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05967				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05961			
Item 23 FilmGill 4/17/69 kk				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First Middle (Last)		2a. DATE OF DEATH		2b. HOUR					
Shere11		Ilene Bryan		Month 4 Day 10 Year 69		6:19					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		4-9-69		YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland						St. Mary's				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Leonardtwn		St. Mary's Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD		St. Mary's		Ridge							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
Julian Leonard Bryan		Cynthia Marie Campbell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				Mother Box 7, Ridge, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
7701											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/9, 1969, to 4/10, 1969, that (I) (we) last saw the deceased alive on 4/10, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
James P. Jarboe, M.D.		4/10/69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		Great Mills, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Apr. 11, 1969		St. Peter Claver Cem.		Ridge Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robinson's		APR 14 1969		Charles Judge							
Leonardtwn, Maryland											

UNITED STATES DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY DIVISION

WASHINGTON, D. C.

June 1934

Report No. 11

11-62-11

PLANT INDUSTRY DIVISION
UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

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UNITED STATES DEPARTMENT OF AGRICULTURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05968									
05962									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
E Griffin			Fad			April Month 26, Day 1969 Year			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		Jan. 5, 1909		60 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				St. Mary's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Park Hall			Courtneys Rest Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			St. Mary's		St. George Island				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Joseph Campbell			Georgiana ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			212-56-2379		Mrs Grace G. Barnes		Piney Point, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>									hrs.
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Sepsis</u>									day
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Infected area on foot</u>									wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Chronic Rheumatoid arthritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 19 65, to 4/20 1969, that (I) last saw the deceased alive on 4/15 1969, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
James P. Jarboe M. D.					4/29/69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					Great Mills, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 29, 1969		St Lukes Cemetery		St George Island, St. Mary's, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. Clarke Mattingley Leonardtown, Maryland					MAY 1 1969		Charles Judge		

20220

James H. Jones, Jr.
April 1, 1961
St. Louis, Missouri
Dear Mr. Jones:
I have received your letter of March 27, 1961, regarding the matter of the St. Louis Convention Center. I am sorry that I cannot give you a more definitive answer at this time, but I am sure that you will understand the need for further study and consultation with the appropriate authorities.

Very truly yours,
James H. Jones, Jr.
Director

4/20/61
4/27/61

James H. Jones, Jr.
Director

St. Louis Convention Center
St. Louis, Missouri
April 1, 1961

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05969

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05963

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH				2b. HOUR	
Millard		Fillmore		Connelly				Month <input checked="" type="checkbox"/> April Day 25, Year 1969				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	August 5, 1888		80 YRS		MONTHS DAYS		HOURS MIN.		Month April Day 25, Year 1969		M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md	
Maryland		USA				St. Mary's							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown		St. Mary's County											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		St. Mary's		Leonardtown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
James		Leftridge		Connelly				Sarah		Bradburn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
No				215-54-8968T		Mary Maude Connelly		Leonardtown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Myocardial Infarction										1 hour			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) Coronary Arteriosclerosis										10 yrs			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASS M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				4-28-69					
William H. Patrick M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Lexington Park, Md.					
ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				April 28, 1969		ST. Aloysius		Leonardtown, St. Mary's, Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley						Leonardtown, Maryland		MAY 1 1969		Charles Judge			

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Country

Product

Quantity

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U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05970		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05964	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR
John Charles Feeser					April Month 18, Day 1969		M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male	White		March 20, 1894		75 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna	U. S. A.			St. Mary's		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Great Mills,				Cabinemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		St. Mary's	Great Mills				
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		
John Charles Feeser					Emma Myers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
		176-01-6102		Claudia N. Feeser Great Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min yes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 19-63 to 4/18/69, that (I) (we) last saw the deceased alive on 4/18/69, and that in (my) (our) opinion death occurred on the date and hour and (from) the causes stated above. (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
<u>James P. Jarboe M. D.</u>				4/18/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
James P. Jarboe M. D.				Great Mills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		April 21, 1969	Trinity Memorial Gardens		Waldorf, Charles, Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley Leonardtown, Maryland				APR 22 1969		<u>William J. Jarboe</u>	

05070

RESULTS OF ANALYSIS

John Carson Jones

March 20, 1944

100.00

Calculated

100.00

John Carson Jones

100.00

Carson and Thompson
Carson and Thompson

Charles Miller

4/18/44

4/18/44
John I. Jones

John I. Jones

April 21, 1944

100.00

100.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (1, 2 and 3) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

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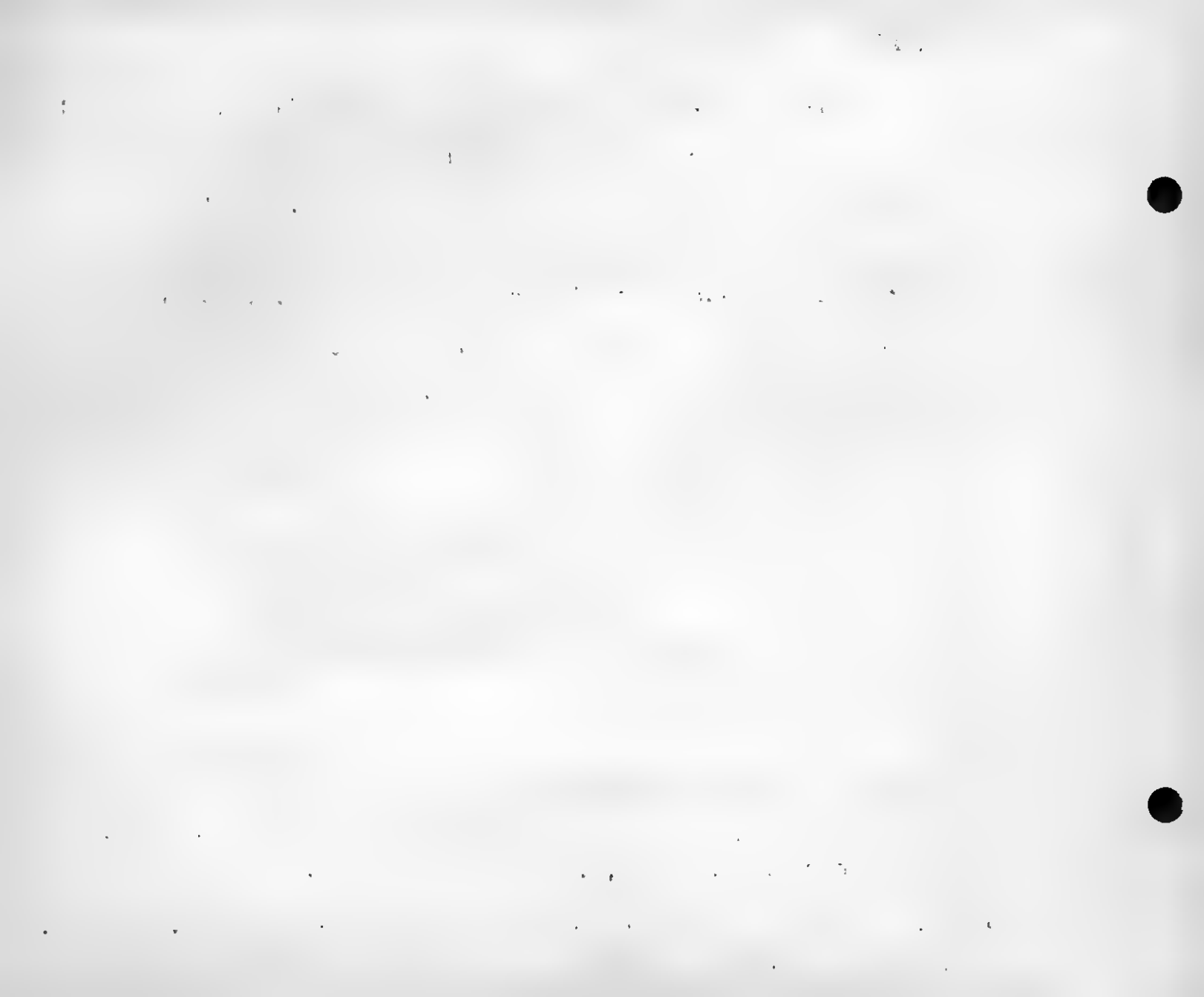
05971

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05965

1 DECEASED-NAME (Type or print) Lisa Marie Henry			2a. DATE OF DEATH Month April Day 14 Year 69			2b. HOUR P 12:08	
3 SEX Female		4 RACE White		5 DATE OF BIRTH April 14, 1969		6. AGE (in years lost birthday) YRS. MONTHS DAYS 1 1 48	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Mary's Md.	
1d. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last Larry Leon Henry		15 MOTHER'S MAIDEN NAME First Middle Last Nancy Janette Guyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mother			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 7167 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John F. Fenwick DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/15/69			
22d. PHYSICIAN'S NAME (Type) John F. Fenwick, M.D.				22e. ADDRESS Leonardtwn, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15, 1969		23c. NAME OF CEMETERY OR CREMATORY St Aloysius Cemetery		23d. LOCATION (City or Town) (County) (State) Leonardtwn, St. Mary's, Md.	
24. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtwn, Maryland				25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE W. Clarke Mattingley	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05972

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05966

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR		
James Allen Hill					XXXXX Month April Day 1 Year 1969		M		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		
Male	Caucasian		August 25, 1912		56 YRS.		MONTHS DAYS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U S A				St. Mary's		Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Leonardtowntown		St. Mary's Hospital				State Road			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		St. Mary's		Bushwood,					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT	
Samuel Hill		Addie Ada Vallandingham						Address	
						Elizabeth G. Hill		Bushwood, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Coronary Infarction</u>								48 hrs	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Sclerema Brachii</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION		Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>April 1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
<u>W.D. Boyd</u>		4-2-69			William D. Boyd M. D.				
					22e ADDRESS				
					Leonardtowntown, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		April 3, 1969		Sacred Heart		Bushwood, St. Mary's, Maryland			
24 FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. Clarke Mattingley Leonardtown, Maryland					DATE APR 7 1969		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05973										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05968									
Item 11, Film 111 4/18/69 km										CERTIFICATE OF DEATH																			
1 DECEASED-NAME (Type or print)					First Estelle Middle Elizabeth Last Jones					2a. DATE OF DEATH					April Month 5, Day 1969					2b. HOUR 1P M									
3 SEX Female					4 RACE Negro					5 DATE OF BIRTH Oct. 10, 1892					6 AGE (in years lost birthday) 76 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS HOURS MIN				
7a BIRTHPLACE (State or foreign country) Maryland					7b CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH St. Mary's Md.														
10 CITY OR TOWN OF DEATH Park Hall					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Courtney's Care Home					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY														
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland					13b COUNTY St. Mary's					13c CITY OR TOWN Lexington Pk.					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e STREET AND NUMBER Route 2 Box 56									
14 FATHER'S NAME First Alfred Middle Mathews Last					15. MOTHER'S M AIDEN NAME First Mary Middle Ella Last Johnson																								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b SOCIAL SECURITY NO 136-22-89835					17 INFORMANT Louise Smith					Address Rt. 2 Box 56 Lexington Park, Md.														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days														
4319 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost															(b) Generalized arterio-sclerosis 4 years														
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No City or Town County State														
22a I certify that (I) (this hospital) attended the deceased from Oct 1, 1968, to April 5, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																													
22b SIGNATURE P. J. Bean M. D.										DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c DATE SIGNED April 7/69									
22d PHYSICIAN'S NAME (Type) P. J. Bean M. D.										22e ADDRESS Great Mills, Maryland																			
23a BURIAL, CREMATION REMOVAL (Specify)					23b DATE April 10, 1969					23c NAME OF CEMETERY OR CREMATORY St. Peter Clavers					23d LOCATION (City or Town) (County) (State) Ridge, St. Mary's, Maryland														
24. FUNERAL DIRECTOR W. Clarke Mattingley										ADDRESS Leonardtown, Maryland					25a REC'D BY REGISTRAR APR 9 1969					25b REGISTRAR'S SIGNATURE Charles Judge									

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05974

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05964

1 DECEASED-NAME (Type or Print) DE LANDIS			First Middle Last McCOY			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> APR. 15 1969			2b HOUR 12:45		
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 9/30/1938	6 AGE (in years last birthday) 30 YRS	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PROMULGATED DEAD Month Day Year APRIL 15 1969			2d HOUR 2:00P
7a BIRTHPLACE (State or foreign country) VIRGINIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ST. MARYS			Md		
10 CITY OR TOWN OF DEATH MECHANICSVILLE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SCHOOL TEACHER			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BOARD OF EDUC.			12b KIND OF BUSINESS OR INDUSTRY		
3a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND			13b COUNTY ST. MARYS		13c CITY OR TOWN MECHANICSVILLE		13d INS DE CITY (M 15?) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER 400 HOLMES, GOLDEN BEACH		
14 FATHER'S NAME First Middle Last CHARLES McCOY			15 MOTHER'S MAIDEN NAME First Middle Last ILA SANDERS								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO 229 44 4303		17 INFORMANT ADDRESS MRS. BETTY P. McCOY SAME AS # 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE INJURIES EXTREME 8199 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year 12:45P 4/15/1969			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) auto accident					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) RT. 235 2 M.I.S. OF RT. 6			21f LOCATION Street or R.F.D. No City or Town County State MECHANICSVILLE ST. MARYS MD.					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE WM. D. BOYD M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4/16/69		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) LEONARDTOWN, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 4/18/69		23c NAME OF CEMETERY OR CREMATORY McCOY CEMETERY			23d LOCATION (City or Town) (County) (State) COEBURN, VIRGINIA			
24a SIGNATURE OF REGISTRAR John M. Welch			24b ADDRESS LEONARDTOWN, MD.			25a REC'D BY REGISTRAR DATE APR 22 1969			25b REGISTRAR'S SIGNATURE Charles J. Under		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARRIED STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
05975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
THOMAS			CLARK			NEWTON			2a. DATE KNOWN OF DEATH		2b. HOUR		2c. DATE PRONOUNCED DEAD		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
Male			White		10-27-1952		16 YRS.		MONTHS		DAYS		2c. DATE PRONOUNCED DEAD		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH			2d. HOUR			
Michigan			USA			NEVER MARRIED			St. Mary's			2d. HOUR			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			2d. HOUR			
Piney Point			St. Georges Creek			STUDENT						2d. HOUR			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Michigan			FLINT			YES			NO			3059 Wagon Trail			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
LOREN			NEWTON			366 55 1065			LOREN NEWTON			3059 WAGON TRAIL RL. FLINT, MICH.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)															
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Undetermined, probably drowning</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) <u>Undetermined, probably drowning</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No			City or Town			County State			
WHILE AT WORK			Water			St. George's Creek			Piney Point			St. Mary's Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED			
Edward F. Wilson, M.D.												4/30/69			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)			
TRANSIT			5-1-69						FLINT, MICHIGAN						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
John M. Welch - Leonard town Md.						MAY 5 1969			Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05976

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) KENNETH			First Middle Last RICHARDSON			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year April 26, 1969			2b HOUR 9:00 AM				
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH March 16, 1949		6 AGE (In years last birthday) 19 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year April 26, 1969			
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Mary's							
10 CITY OR TOWN OF DEATH Lexington Park				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 655 Chinlee Drive				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland				13b COUNTY St. Mary's				13c CITY OR TOWN Lexington Park		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 655 Chinlee Drive	
14. FATHER'S NAME Edifford			First Middle Last Richardson			15. MOTHER'S MAIDEN NAME Joslin			First Middle Last Oldham				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Mother Same as #10 + 11					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Purulent Otitis Media DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Ronald N. Kornblum				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 4/27/69	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
								ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION REMOVAL (Specify) Burial				23b DATE April 28, 1969		23c NAME OF CEMETERY OR CREMATORY Zion Fair Cemetery				23d LOCATION (City or Town) (County) (State) Herrmansville, St. Mary's, Md.			
24 FUNERAL DIRECTOR W. Clarke Mattingley				ADDRESS Leonardtown, Maryland				25a REC'D BY REGISTRAR DATE MAY 1 1969		25b REGISTRAR'S SIGNATURE Richard S. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1X48

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05977									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR
Raymond			Harold SHAW			April 20 1969			1220 M
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		June 9, 1925		43 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Ohio		U.S.				St. Mary's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
NAS, Patuxent Riv., Md.			Naval Hospital			U.S. Air Force, Retired			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			St. Mary's		Dameron				Post Office
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William Arnold Shaw			Nola Gens						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT Address				
Yes			269-20-7995		Official Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4101 DUE TO, OR AS A CONSEQUENCE OF Acute Myocardial Infarction (b) DUE TO, OR AS A CONSEQUENCE OF (c) 4 days APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) person attended the deceased from 18 April, 1969, to 20 April 1969, that (I) we last saw the deceased alive on 20 April 1969, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death.									
22b SIGNATURE <i>S. G. Georgiou</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 20 April 1969		
22d PHYSICIAN'S NAME (Type) S. G. GEORGIOU, LCDR MC USNR					22e ADDRESS Naval Hospital, NAS, Patuxent River, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		April 23, 1969		Friendship			Ridge, St. Mary's, Maryland		
24. FUNERAL DIRECTOR V. Clarke Mattingley, Leonardtown, Md.					25a. REC'D BY REGISTRAR DATE MAY 14 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 5&6 Film 0111

4/22/69

05973

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05973

1 DECEASED-NAME (Type or Print)				2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> April 12, 19 69				2b. HOUR M	
Otto Herman Stasch									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	IF UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR M
Male	White	March 14, 1914	55 YRS					19	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		U S A				St. Mary's			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not n hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Leonardtwn,		St. Mary's Hospital		Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		St. Mary's		Mechanicsville					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
August Stasch				Dorothea Sophia Redies					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS			
				Mary C. Stasch		Mechanicsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Barbiturate ingestion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 min</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR <u>4-12</u> P.M. 19 <u>69</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Self induced overdose of Barbiturate</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>at Home</u>		21f. LOCATION Street or R.F.D. No <u>Charlotte Hall</u>		City or Town <u>St Mary</u>		County <u>Md</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>W.D. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>4-15-69</u>	
EXAMINER'S NAME (Type) William D. Boyd M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 16, 1969		St Paul Lutheran Cemetery		Charlotte Hall, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG STRAR DATE		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley				Leonardtwn, Maryland		APR 17 1969		<u>Charles Judge</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05979

CERTIFICATE OF DEATH

05979

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR M	
Dorothy Lincoln Edson Swann					April 12, 1969			
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.
Female	Caucasian		April 21, 1890		78 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Pennsylvania	U. S. A.				St. Mary's Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Leonardtwn		St. Mary's Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		St. Mary's		Leonardtwn				
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
Charles Henry Edson					Elizabeth V. Yarnell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address				
		162-03-1023		J. Compton Swann P.O. Box 270 Leonardtown, Md.				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> -109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>48 hr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED		
John F. Fenwick M. D.						4/15/69		
22d. PHYSICIAN'S NAME (Type)		John F. Fenwick M. D.		22e ADDRESS		Leonardtwn, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		April 14, 1969		Christ Church Cemetery		Chaptico, St. Mary's, Maryland		
24. FUNERAL DIRECTOR		W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland		25a. REC'D BY REGISTRAR DATE APR 17 1969		25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Paul James Walker						April Month 13 Day 1969		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
Male		White		Sept. 7, 1900		77 68 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		U.S.A.				St. Mary's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtown			St. Mary's Hospital			Store Merchant				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			St. Mary's		Abell					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Lorenzo Walker			Alice Josephine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			218-18-0461		James P. Walker California, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>CVA</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 13, 1969, to April 13, 1969, that (I) (we) last saw the deceased alive on April 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W.D. Boyd</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-69			
22d. PHYSICIAN'S NAME (Type) William D. Boyd M. D.					22e. ADDRESS Leonardtown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		April 15, 1969		Sacred Heart Cemetery		Bushwood, St. Mary's, Maryland				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley Leonardtown, Maryland					DATE APR 18 1969		<u>Charles Judge</u>			

05320

STATE OF TEXAS

COUNTY OF DALLAS

1933

March 13

Friday

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March 13

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March 13

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March 13

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05981					05976				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Mary Louise StClair Zellers					2a. DATE OF DEATH April Month 26 Day Year 1969			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 8, 1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Mary's Md.			
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Avenue		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Peter St. Clair			15. MOTHER'S MAIDEN NAME First Middle Last Julia Cheseldine						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577-01-5165 A		17. INFORMANT Address Julia S. Webb Avenue, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF (c) Cornary Artery Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Sclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. days yrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 4/26/69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 4/26, 1969 , that (I) (we) last saw the deceased alive on 4/26 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Patrick Jarboe M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/26/69		
22d. PHYSICIAN'S NAME (Type) J. Patrick Jarboe M. D.					22e. ADDRESS v vvv Great Mills, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/26/69		23c. NAME OF CEMETERY OR CREMATORY Maryland State Anatomy Board		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland					25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE McLennan Cusack		

Received of the
 Treasurer of the
 State of New York
 the sum of \$100.00
 for the purchase of
 land in the town of
 Canaan, Co. of
 Sullivan, N. Y.
 for the purpose of
 establishing a
 school for the
 education of the
 children of the
 Indians of the
 reservation at
 Canaan, N. Y.
 This receipt is
 given in full for
 the sum of \$100.00
 and no other receipt
 is required.
 Witness my hand
 and the seal of the
 State of New York
 this 1st day of
 January, 1862.
 Governor of the
 State of New York

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